	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
		155246	A. BUILDING B. WING	00	07/25/2014
	PROVIDER OR SUPPLIE S OF DUNELAND T		110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000000	State Licensure included the Inv IN00152400. Complaint IN00 no deficiencies rare cited.	r: 155246 00267000 I, RN-TC RN RN RN E)	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000150

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155246		(X2) MUL' A. BUILDI B. WING		00	(X3) DATE : COMPL 07/25/	ETED	
	PROVIDER OR SUPPLIER			110 BEV	DDRESS, CITY, STATE, ZIP CODE /ERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID ÆFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	cited in accordar	es reflect State findings ace with 410 IAC 16.2. ompleted on July 29, Kulik, RN.					
F000225 SS=D	have been found of neglecting, or mist court of law; or har into the State nurs abuse, neglect, mistappropriation of any knowledge it haw against an emindicate unfitness or other facility staregistry or licensing	EPORT IDIVIDUALS of employ individuals who guilty of abusing, reating residents by a we had a finding entered e aide registry concerning streatment of residents or of their property; and report has of actions by a court of ployee, which would for service as a nurse aide ff to the State nurse aide g authorities.					
	violations involving abuse, including ir and misappropriat are reported immediadministrator of the officials in accordathrough established the State survey and abuse of the state survey are state survey and abuse of the state survey and abuse of the state survey and abuse of the state survey are state survey and abuse of the state survey are state survey and abuse of the state survey and abuse of the state survey are state survey and abuse of the state survey and abuse of the state survey and abuse of the state	nsure that all alleged g mistreatment, neglect, or niguries of unknown source ion of resident property idiately to the e facility and to other ance with State law and procedures (including to nd certification agency).					
	alleged violations						

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Event ID:

TCSR11

Facility ID: 000150

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155246	B. WIN	G		07/25	/2014
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VERLY DR		
WATERS	OF DUNELAND T	HE		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	potential abuse wi progress.	hile the investigation is in					
	progress.						
	reported to the ad designated repres officials in accorda (including to the S certification agency the incident, and it verified appropriate be taken. Based on record	sentative and to other sance with State law state survey and cy) within 5 working days of f the alleged violation is te corrective action must review and interview,	F00	0225	It is the practice of The Water Duneland to constitute our	s of	08/24/2014
	the facility failed to promptly report a				creditable allegation of		
	resident to reside				compliance with all regulation	s	
		e Administrator. The			requirements. 1. The actions		
	1	ed to notify the State			taken are as follows: a. The		
		egation of verbal abuse		allegation of abuse by R 32 w reported to the ISDH on			
	for 2 of 2 allegat	tions reviewed.			7/24/2014 b. The investigati	on	
	(Resident #32)				of allegation was completed o		
	Findings include	e: or Resident #32 was			7/24/2014 2. The facilities actions taken to identify other residents are as follows: a. Nother residents identified. 3.	lo Γhe	
		2/14 at 1:55 p.m. The			measures put into place are a follows: a. All residents who	S	
		nitted to the facility on			went out on pass with		
		e hospital. The resident's			family/friends were interviewe		
		led, but were not limited			related to abuse b. All staff w		
		sion disorder, failure to			re-inserviced on the abuse po and reporting procedures. 4.	-	
					facility will monitor actions as	1110	
	_	od pressure, anxiety, and			follows: a. D.O.N. and/or		
	mixed personalit	ty traits.			designee will monitor the 24 h		
	dated 7/16/14, in argumentative or	rsician Progress Note adicated "remains in a daily basis. Also all regarding ability to			board and nurses notes daily any allegation of abuse. b. D.O.N. and/or designee will interview each resident who g out on pass with family/friends any allegations of abuse per	oes	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155246	B. WIN	G		07/25/	2014
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
101111111111111111111111111111111111111	NO VIDEN ON DOLLER				VERLY DR		
WATERS	OF DUNELAND T	HE		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	care for herself.	She continues to have			facilities resident sign out book		
	problem solving	skills. I do not see how			daily times 1 month, then 3 da a week times 3 months, then	ys	
	she can live in th	e community			re-evaluate and determine the		
	independently as	she has no problem			need to continue to monitor.	C.	
	solving skills and	d is frequently illogical			The Administrator and/or		
	and irrational."				designee will report all allegati	ons	
					of abuse to the ISDH per reporting requirements. d. TI	20	
	Review of Nursi	ng Progress Notes dated			Administrator and/or designee		
		a.m., indicated "Resident			review all reports of concern a		
		out on pass with her			ISDH reportable occurrences		
		plaints of being verbally			the monthly QA meeting and a		
	abused in the par	•			the quarterly QA meeting with Medical Director. The QA tean		
	_	lent to keep negative			will review audits for 6 months		
	_	r life and asked if she			Once 100% compliance is	-	
		ormed writer that she was			reached the QA team will		
					determine when monitoring wi		
		tated, I'm sorry that he			stop. e. All new employees v		
	_	to you. Resident went			be inserviced on abuse, abuse policy and reporting. 5. Our day		
		around 7:25 p.m. writers			of compliance is 8/24/2014	alc	
	_	olice were on the phone					
		writer to make sure					
	resident was ok.	As she was on the					
		e at that very moment					
	_	erbal abuse with an					
	officer. Writer f	ound resident to be on					
	her cell phone ta	lking to police and stated					
	she's ok to cowo	rker who was still on the					
	phone with offic	er." (sic)					
	Review of the 7/	8/14 Social Service					
		dicated "reviewed with					
	_	phone call with police					
	^	has been a pattern in the					
		dent was living in					
	_	is well documented by					
		is well documented by					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155246		LDING	00	07/25	
		100240	B. WIN		PPPPGG GYMY GM MP GYP GOPP	01720	2014
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE VERLY DR		
WATERS	OF DUNELAND T	HE			ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ained to resident she					
		to call police when they					
do argue. Resident wants the police to							
		t to talk to her that way.					
		not to speak to her friend					
	_	ke with resident's friend					
	(name) and told	him they should not see					
	or talk to each of	ther for awhile."					
	Continued review	y of Nursing Progress					
Continued review of Nursing Progress Notes dated 7/21/14, at 11:40 p.m.,							
	* * *						
	indicated "CNA came to writer and said she needs help in resident room with						
	_						
		ident she was assisting.					
		erfering with her care by					
		rom the bathroom while					
	_	etting changed and ready					
		explained that she tried to					
	_	nt that she can't do that;					
		ntitled to her privacy					
		nged. Resident went onto					
	~	was bossy and she					
		be talked to like she is 4					
	_	ther nurse and I tried to					
	_	just trying to take care					
		nts equally. Resident					
		all kinds of naked					
		and other resident were					
	_	oesn't matter. She went					
	· ·	use other nurse calling					
		d, 'You act just like my					
	1	e mean just like him.'					
		vorker was not in anyway					
	raising his voice	or 'being mean' to					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		155246	B. WIN	G		07/25/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF DUNELAND TH	HE			VERLY DR ERTON, IN 46304		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s just trying to help					
	writer explain that roommate is entitled						
		nile being changed.					
		s continuing to talk/argue					
		eause she kept bringing					
	other negative th						
	· · · · · · · · · · · · · · · · · · ·	other aid came to talk to					
		fferent matter and					
		aide of opening her					
	bathroom door a						
	-	sidents walked up and					
	_	sident to calm down and					
		o cuss at them. Other					
		ussing back and writer					
	•	middle and send them					
	-	riter escorted resident					
		. Resident continued to					
		room and argue with					
	writer for 30 min	lutes."					
	Interview with th	ne Administrator on					
	7/24/14 at 10:00	a.m., indicated there had					
		ons of abuse the facility					
	had reported to the	-					
	regarding Reside	• •					
		e Administrator on					
	7/24/14 at 2:30 p	.m., indicated he was					
	-	resident to resident					
	altercation regard	ling the verbal					
	_	Resident #32 and the					
		nts. He further indicated					
	at the time, that b	ooth incidents had not					
		the State Agency.					
	_	2 ,					
			<u> </u>				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 07/25 /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F000226 SS=D	ETC POLICIES The facility must describe an instreatment, negresidents and missiproperty. Based on record the facility failed policy regarding resident to reside altercation to the notifying the the allegation of vertallegations reviet facility also failed services, who has residents, were mustice Act. Findings includes 1. The record for reviewed on 7/22 resident was admustice 5/20/14 from the diagnoses included to, major depressions.	review and interview, It to follow their Abuse promptly reporting a ent verbal abuse Administrator and State Agency of an bal abuse for 2 of 2 wed. (Resident #32) The ed to ensure all contracted d contact with the made aware of the Elder	F000	0226	It is the practice of The Waters Duneland to constitute credital allegation of compliance with a regulatory requirements. 1. The actions taken are as follows: The allegation of abuse by R3: was reported to the ISDH on 7/24/2012 b. The investigation of allegation was completed on 7/24/2014 2. The facilities activated to identify other resident are as follows: a. No other residents identified 3. The measures put into place are as follows: a. All residents who went out on pass with family/friends were interviewed related to abuse b. All staff were re-inserviced on resident resident abuse 4. The facility with monitor actions as follows: a. D.O.N. and/or designee will monitor the 24 hour board and nurses notes daily for any allegation of abuse. b. D.O.N. and/or designee will interview each resident who goes out or	ble all ne a. 2 on n ons s d t to vill	08/24/2014

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPLI	ETED
		155246	A. BUII			07/25/	2014
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\A/ATEDO	OF DUNELAND T				VERLY DR		
WATERS	OF DUNELAND T	ПЕ		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	mixed personalit	y traits.			pass with family/friends for any		
					allegations of abuse per faciliti		
	Review of a Phy	sician Progress Note			resident sign out book Daily tir	nes	
	dated 7/16/14, indicated "remains				1 month, then 3 days a week		
					times 3 months, then re-evalua and determine the need to	ale	
	-	n a daily basis. Also			continue to monitor c. The		
		al regarding ability to			Administrator and/or designee	will	
	care for herself.	She continues to have			report all allegations of abuse		
	problem solving	skills. I do not see how			the ISDH per reporting		
	she can live in th	e community			requirements d. The		
	independently as	she has no problem			Administrator and/or designee		
	-	d is frequently illogical			review all reports of concern a		
	and irrational."	a is frequently mogical			ISDH reportable occurrences a		
	and mational.				the monthly QA meeting and a		
					the quarterly QA meeting with Medical Director. The QA team		
		ng Progress Notes dated			will review audits for 6 months		
	7/8/14, at 12:11	a.m., indicated "Resident			Once 100% compliance is	•	
	came back from	out on pass with her			reached the QA team will		
	boyfriend. Com	plaints of being verbally			determine when monitoring wil	I	
	abused in the par				stop. e. All new employees v	vill	
	-	lent to keep negative			be inserviced on abuse, abuse		
	_				policy and reporting. 5. Our da	te	
		life and asked if she			of compliance is 8/24/2014 1.		
		ormed writer that she was			The actions taken are as follow		
	fine and writer s	tated, I'm sorry that he			 a. 100% audit of all contracte vendors was completed. All 	u	
	said mean things	to you. Resident went			vendors did not have the Elder		
	to her room. At	around 7:25 p.m. writers			Justice Act information. 2. The		
	coworker said po	olice were on the phone			facility actions taken to identify		
	-	writer to make sure			other are as follows: a. No		
		As she was on the			residents were affected by the		
					deficient practice 3. The		
		e at that very moment			measures put into place are as	6	
	_	erbal abuse with an			follows: a. All contracted		
	officer. Writer f	ound resident to be on			vendors were sent letters	,	
	her cell phone talking to police and stated she's ok to coworker who was still on the				explaining the Elder Justice Ac		
					was also attached 4. The facili	-	
	phone with offic	er." (sic)			will monitor as follows: a. The	-	
					Administrator and/or designee		

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	07/25/2014
NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	(X5) COMPLETION DATE
Review of the 7/8/14 Social Service Progress Note indicated "reviewed with resident the telephone call with police last night. This has been a pattern in the past. When resident was living in community and is well documented by Physician. Explained to resident she cannot continue to call police when they do argue. Resident wants the police to tell her friend not to talk to her that way. Resident agreed not to speak to her friend for awhile. Spoke with resident's friend (name) and told him they should not see or talk to each other for awhile." Continued review of Nursing Progress Notes dated 7/21/14, at 11:40 p.m., indicated "CNA came to writer and said she needs help in resident room with roommate of resident she was assisting. Resident was interfering with her care by walking to and from the bathroom while roommate was getting changed and read for bed. CNA explained that she tried to explain to resident that she can't do that; that resident is entitled to her privacy while being changed. Resident went onto argue that CNA was bossy and she 'doesn't need to be talked to like she is 4 year old.' The other nurse and I tried to explain we were just trying to take care of all our residents equally. Resident stated she's seen all kinds of naked women and her and other resident were	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL	
ANDILAN	OI CORRECTION	155246		LDING	00	07/25/	
		100270	B. WIN		PPPPG GWW GW == == ==	01/23/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF DUNELAND T	HE			VERLY DR ERTON, IN 46304		
(X4) ID		FATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	both girls so it do	pesn't matter. She went					
	•	use other nurse calling					
	_	d, 'You act just like my					
		mean just like him.'					
	This writer's cow	vorker was not in anyway					
	raising his voice	or 'being mean' to					
	resident. He was	s just trying to help					
	writer explain the	at roommate is entitled					
	to her privacy wl	hile being changed.					
	While writer was	s continuing to talk/argue					
	with resident bed	cause she kept bringing					
	other negative th	ings up into the					
	conversation, and	other aid came to talk to					
	writer about a di	fferent matter and					
	resident accused	aide of opening her					
	bathroom door as	nd looking at her					
	privates. Two re	esidents walked up and					
	said nicely for re	sident to calm down and					
	resident started to	o cuss at them. Other					
		sussing back and writer					
	-	e middle and send them					
	_	riter escorted resident					
		. Resident continued to					
		room and argue with					
	writer for 30 min	nutes."					
		irrent 6/1/2010 Abuse					
		ey provided by the					
		n 7/24/14 at 3:10 p.m.,					
		resident has the right to					
		oal, sexual, physical, and					
		poral punishment,					
	involuntary seclu						
	misappropriation	of their property					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		155246	B. WIN			07/25/	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF DUNELAND TH	HE			VERLY DR ERTON, IN 46304		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		netimes referred to as					
	"events"). Residents will not be						
		n events by anyone,					
	•	t limited to, facility					
	•	ents, consultants or					
	· ·	or other agencies serving					
	· ·	ily members, or legal					
	_	s or other individuals.					
		as the use of oral,					
	written, or gestur						
		d disparaging and					
		to resident or their					
		n their hearing distance,					
	regardless of their						
	understand, or di	-					
		the designee who is in					
	-	ility, shall report any					
	_	ected abuse, neglect, or					
		of resident property to					
	the Department of	of Health as required."					
	Interview with th	ne Administrator on					
	7/24/14 at 10:00	a.m., indicated there had					
	been no allegatio	ons of abuse the facility					
	had reported to the	he State Agency					
	regarding Reside	ent #32. Further					
	interview with th	e Administrator on					
	7/24/14 at 2:30 p	.m., indicated he was					
	not aware of the	resident to resident					
	altercation regard	ding the verbal					
	_	Resident #32 and the					
		nts. He further indicated					
	at the time, that b	ooth incidents had not					
	•	the State Agency.					

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PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		155246	B. WIN	G		07/25/	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATEDS	COE DUNELAND T	LIE.			VERLY DR ERTON, IN 46304		
	OF DUNELAND TH			<u> </u>	ERTON, IN 40304		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1110	ALGOLINGAT OR	250 152.111 111.0 111 0111.1110.1)					5.112
	Interview with L	PN #2 on 7/24/14 at					
		ted he was one of the					
	nurses working the night Resident #32						
	_	bal aggression with					
	_	e two other residents.					
	He indicated the	resident was swearing					
		set. He indicated two					
		ame up to the resident					
		her down, but Resident					
	#32 became more upset and started						
	swearing at them was becoming verbally						
	aggressive. He indicated one of the						
	residents started	swearing back at the					
	resident, and he l	had to physically step in					
		dents to make sure					
	Resident #32 was	s not going to hit one of					
	them. He indicat	ted Resident #32's verbal					
	aggression was e	scalating. LPN #2					
	indicated he did	not immediately notify					
	the Administrato	r or Director of Nursing					
	of the resident to	resident altercation.					
		h the Administrator on					
	7/25/14 at 9:30 a	.m., indicated he had not					
	sent out any Elde						
	information to th	e contracted services					
		ility on a daily or					
		He further indicated he					
	had not given any						
		macy, Registered					
		lance Company or					
	-	s. The Administrator					
	indicated those c	ontracted services have					

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155246	B. WING 07/25/2014				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F000241 SS=D	interact with the 3.1-28(a) 483.15(a) DIGNITY AND RE INDIVIDUALITY	SPECT OF					
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure each residents' dignity was maintained related to being called by their name during 1 of 1 meal observations. (Resident #50) The facility also failed to ensure volunteer groups knocked on the residents' doors prior to entering rooms for 1 of 2 residents reviewed for dignity of the 2 that met the criteria for dignity. (Resident #12) The facility also failed to ensure a resident's medical concerns were discussed in private without being overheard by others during a random observation for 1 resident. (Resident #31) Findings include:		F00	0241	It is the practice of The Waters Duneland to constitute credital allegation of compliance with a regulatory requirements 1. The action taken by the facility are follows: a. R 50 was interviewand was unable to recall incide in Main Dining Room on 7/21/2014 d/t cognition. R 50's son was also called r/t to incid in Main Dining Room and had concerns. b. R 12 was interviewed by social services activities. R12 was notified that church group will not be inviting resident to church services. CR 31 was interviewed r/t Doctor appointment on 7/22. R 31 was unable to recall appointment of discussion of confidential med information. 2. The actions take to identify others are as follows a. Interview with residents. No	ble all as wed ent and and at g cr s or ical een s:	08/24/2014

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155246				07/25/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
\\/\TED(OF DUNELAND T	UE			VERLY DR		
WATERS	WATERS OF DUNELAND THE			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. On 7/21/14 a	t 12:14 p.m., Resident			further residents effected by		
	#50 was observe	ed in the Main Dining			deficient practice b. The facil	-	
	Room. CNA #3	was overheard calling			has identified residents who do not want to be invited to churc		
	the resident "hor	ney" rather than by her			services c. Residents were	''	
		ctor of Nursing was also			interviewed for discussion of		
		dining room at this time			disclosure of confidential medi	cal	
		"honey" rather than by			information. No further residen	its	
		noney rather than by			were affected by the deficient		
	their name.				practice. 3. The measures put		
					into place are as follows: a. /		
	The record for R	lesident #50 was			staff was re-inserviced on Digr respect, resident rights and	iity,	
	reviewed on 7/2	1/14 at 11:16 a.m.			choice of visitors b. D.O.N. v	vas	
	Review of the resident's Annual				re-inserviced on dignity and	140	
	Minimum Data	Set (MDS) Assessment			confidentiality c. Policy was i	put	
		ndicated the resident's			into place that states "It is the		
	•	for Mental Status (BIMS)			policy of this facility to maintain		
		, ,			Resident Rights, Dignity, priva	-	
		npleted. The resident			and choice of visitors. d. Chu	ırcn	
		s having short and long			groups were sent a letter regarding inviting residents an	۱ ا	
	term memory pr				knocking on residents doors.		
		h Resident #12 on			new church groups involved at	-	
	7/22/2014 at 11:	00 a.m., indicated there			facility will be informed by lette		
	was one church	group that came to the			4. The facility will monitor action	ons	
	facility every Sa	turday. She indicated the			as follows: a. D.O.N. and/or		
	people in the chi	arch walk up and down			designee will monitor dining		
	1 ^ ^	ask the residents if they			rooms every meal for dignity a respect everyday times 1 mon		
	_	urch. They do not knock			then 3 times a week times 3	uı,	
	_				months, then re-evaluate and		
	1	just walk in my room.			determine the need to continue	e to	
		they should announce			monitor. b. D.O.N. and		
		not come into her room			or/designee will monitor nursing		
		She further indicated if			staff randomly for confidentiali		
	my door was op	en they would look in my			of residents medical condition	ა	
	room and that bo	othered her.			times a week times 1 month, then 2 days a week times 3		
					months, then will determine if	_{he}	
	Another intervie	w with the resident on			need to monitor. c.		
					Administrator and/or designee		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155246			LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/25/	ETED	
	ROVIDER OR SUPPLIER		•	110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
IAU	still upsetting to group that comes Saturday. She in think they should and down the had especially the chanck on the door. The record for R reviewed on 7/22 resident's diagnor not limited to, and bifida, chronic be psychotic feature. Review of Quart (MDS) Assessme indicated the resident had problems. The resident had problems. The resident had problems. The resident had problems assist with one pubed mobility. The limited assist with assist for transfer. Interview with A Director on 7/24 indicated she was a Church group Saturday morning.	her regarding the church is to the facility every edicated she does not it be allowed to walk up alloway and look in rooms, ildren and they do not ors before entering. esident #12 was 8/14 at 10:18 a.m. The ses included, but were existely, insomnia, spinal ack pain, depression with es, and bipolar. erly Minimum Data Set ent dated 7/8/14 ident had a BIMS (Brief intal Status) score of 15 as alert and oriented. In mood or behavior esident needed extensive erson physical assist for the resident needed ich one person physical ris. essistant Activity /14 at 9:15 a.m., is the person who made dule. She indicated there oup that came every g to the facility. She		1/1/0	monitor audits in the monthly of meeting and in the quarterly of meeting with the Medical Direct The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our Da of compliance is 8/24/2014.	A ctor.	DATE
	•	g to the facility. She y staff were not always					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
ANDILAN	or connection	155246		LDING		07/25/	
		100240	B. WIN		PRESIDENCE CONTROL OF CORP.	017207	2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE VERLY DR		
WATERS	OF DUNELAND T	HE			ERTON, IN 46304		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	working on Satu	rdays when the church					
	came, therefore t	he church group					
	gathered the resi	dents for church					
	services. She in	dicated it depended on					
	the time of the y	ear of how many people					
	came to the facil	ity from the church					
	group. She did i	ndicate children also					
	came to the facil	ity with the church. The					
	Assistant Activit	y Director indicated the					
	church members	do walk up and down					
	the hall and invit	e the residents to church					
	and she had instr	ructed the church director					
	they had to knoc	k on the resident doors					
	before entering,	however, since Activity					
	Staff were not al	ways at the facility					
	working on Satu	rdays she had no way of					
	assuring the chui	rch members did this or					
	not.						
	ar a taran	A 22 22 D2					
		ne Activity Director on					
		a.m., indicated she was					
		was a problem with that					
		nocking on the resident					
		e indicated she would					
	address the issue	with the director today.					
	3. On 7/22/14 at	3:02 p.m. Resident #31					
		ting in her wheelchair					
		the Nurse's Station. At					
	_	rector of Nursing as well					
		mbers were behind the					
		There was also other					
		by the Nurse's Station.					
		on Employee walked up					
		r - J					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155246	B. WIN			07/25/20	U14
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					VERLY DR		
	OF DUNELAND T			<u> </u>	ERTON, IN 46304	<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE (COMPLETION DATE
TAG		and asked her if she was		TAG			DATE
		e Director of Nursing					
	immediately jum	•					
		d stated in a very loud					
		wing that thing frozen off					
		Transportation Employee					
		Director of Nursing					
	•	e Director of Nursing					
		"He is doing it in the					
	doctor's office."						
	2000013 011100.						
	The record for R	Lesident #31 was					
		5/14 at 10:10 a.m. The					
		ses included but were					
	_	ementia and depressive					
	disorder.	1					
	Review of the 7/	5/14 Quarterly Minimum					
	Data Set (MDS)	Assessment indicated					
	the resident's Bri	ief Interview for Mental					
	Status (BIMS) so	core was 10 indicating					
	the resident had	some cognitive					
	impairment. The	e resident needed					
	extensive assista	nce with one person					
	physical assist fo	or locomotion on and off					
	the unit.						
	Interview with the	ne Administrator on					
		n.m., indicated the					
		ing should not have					
	1	about the resident's					
	health condition.						
	3.1-3(t)						

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TCSR11

Facility ID: 000150

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246 NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304 ID PROVIDERS PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED 07/25/2014				
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTION CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
F000282 SS=D	CARE PLAN The services provifacility must be propersons in accordation written plan of care Based on observation interview, the factor resident's Physical followed related treatment for 1 or for pressure ulcement the criteria for (Resident #12) Findings include 1. On 7/23/14 at observed perform treatment for Resident was on her back. The roll onto to her lessore was observed between the resident was red with clear observed on the posserved on the posserved wound. The area	ance with each resident's e. ation, record review and eility failed to ensure the ian Orders were to a pressure ulcer f 3 residents reviewed rs of the 3 residents who for pressure ulcers.	F000282	It is the practice of The Waters Duneland to constitute credita allegations of compliance with regulatory requirements. 1. The action taken as follows: a. Resulting wound treatment was completed as ordered upon nurse identifying displacement of treatment. 2. The facility's act taken to identify others is as follows: a. 100% audit of all resident with wound treatment was completed for proper placement. No further identified 3. The measures put into place are as follows: a. D.O.N. and designee will check residents random halls with wound treatment for proper placement times a week times 1 month, the statement for proper placement is a times a week for 3 months at then re-evaluate the need to continue. b. Nursing assistant were re-inserviced on not removing wound treatments a notifying the licensed nurse immediately if treatment is not intact. 4. The facility will monit actions as followed: a. D.O.I and/or designee will check residents on random halls with wound treatment for proper placement 5 times a week times.	ble all he all he 12 hed he he hed he hed he hed he hed he hed he	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING B. WING	- •	07/25/2014
	PROVIDER OR SUPPLIER S OF DUNELAND THE	STREET.	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR TERTON, IN 46304	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	sponge observed covering the wound after the resident's brief was pulled down and her buttocks were spread. He further indicated it could have come off during care. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, anxiety, insomnia, pulmonary embolism, spinal bifida, chronic back pain, depression with psychotic features, bipolar, hypothyroidism, hyperglycemia, and hyperlipidemia. Review of Physician Orders dated 7/8/14 indicated cleanse sacral wound with normal saline. Apply fibersol to wound bed, cover with folded 4 by 4 gauze. Apply new fibersol every Tuesday, Thursday, and Saturday. Change 4 by 4 gauze twice a day and as needed (prn) for dislodgement. Interview with the Assistant Director of Nursing on 7/24/14 at 2:30 p.m., indicated she measured and kept track of all the wounds in the facility. She further indicated the gauze sponge was to be changed two times a day and as needed if it would have fallen off. She indicated the pressure ulcer should have been covered.		1 month, then 3 times a weed 3 months and then re-evaluathe need to continue. b. The Administrator and/or designer monitor audits in the monthly meeting and in the quarterly meeting with the Medical Director The QA team will review auditor 6 months. Once 100% compliance is reached the Quartern will determine when monitoring will stop. 5. Our conformal of completion is 8/24/2014	te ee will y QA QA ector. its

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, ,		(X2) MULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		155246	B. WING		07/25/2014		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
WATERS	OF DUNELAND T	HE	110 BEVERLY DR CHESTERTON, IN 46304				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)	TAG		DATE		
	3.1-35(g)(2)						
F000309 SS=D	must provide the reservices to attain of practicable physic psychosocial well-the comprehensive care. Based on observinterview, the fact areas of bruising monitored for 1 of for skin condition of the 6 residents skin conditions ((Resident #1)) Findings include On 7/21/14 at 2:: observed with a purple/bluish bruileft hand. On 7/22/14 at 9:: again observed with a purple/bluish bruileft hand.	BEING st receive and the facility necessary care and or maintain the highest al, mental, and being, in accordance with e assessment and plan of ation, record review and cility failed to ensure were assessed and of 3 residents reviewed ns (non-pressure related) s who met the criteria for non-pressure related).	F000309	It is the practice of The Waters Duneland to constitute credita allegations of compliance with regulatory requirements. 1. To actions taken by the facility are follows: a. Head to toes assessment was completed on 1. no further issues were identified. 2. The facility's action taken to identify other resident are as follows: a. No further residents were affected by the deficient practice. 3. The measures put into place by the facility are as follows: a. Re-inservice nursing staff on completing through skin assessments for any areas of discolored skin or areas of discoloration and documentation on the weekly assessment. 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor completed weekly skin assessments and observe by	ble all he e as n R on ts skin II		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLE	ETED
		155246	A. BUI. B. WIN	LDING		07/25/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			VERLY DR		
WATEDS	OF DUNELAND T	HE			ERTON, IN 46304		
	VATERS OF DONELAND THE			CITEST	LICTON, IN 40304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 7/23/14 at 8:	27 a.m. and 1:43 p.m., an			observation 5 times a week tin	nes	
	area of dark purp	ole discoloration was			1 month, then 3 times a week		
	observed above	the thumb area of the			times 3 months and then re-evaluate the need to continu		
	resident's left ha	nd. The area of			b. The Administrator and/or	ue.	
		scoloration remained to			desigee will monitor audits in t	he	
		sident's left hand.			in monthly QA meeting and in		
	l life top of the res	ordent's left hand.			quarterly Qa meeting with the		
	0 7/04/14 : 0	00 41 11			Medical Director.The QA team		
		00 a.m., the resident was			will review audits for 6 months	.	
		Rehab dining room. The			Once 100% compliance is		
	area of bluish dis	scoloration remained to			reached the QA team will determine when monitoring wi		
	the top of the res	sident's left hand and			stop. 5. Our date of compliance		
	thumb area.				is 8/24/2014		
					10 0/2 1/20 1 1		
	The record for R	esident #1 was reviewed					
		34 p.m. A Physician's					
		4, indicated the resident					
		spirin 81 milligrams					
	(mg) daily.						
	Review of the W	eekly Skin Sheet dated					
		ed the resident had no					
	areas of bruising						
	arous or oraising	•					
	Daviou of the W	Josephy Clain/Wound Chast					
		eekly Skin/Wound Sheet					
	· ·	idicated the resident's left					
	_	ar had healed. There					
	was no documen	tation related to the					
	bruise on the res	ident's left hand.					
	A Weekly Skin	Assessment dated					
	1	i.m., indicated the					
	_	t hand (back) bruise 7.5					
		x 7.5 cm, purple bruise					
	related to blood	draw. Resident noted to					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155246	A. BUILDING 00		COMPLETED 07/25/2014		
		133240	B. WIN			011231	2014
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF DUNELAND TI	HE			VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	have purple bruis No edema noted, being tender to to MD notified, no party called, will The area was ide wound." Interview with th (DoN) on 7/24/1 indicated the bru yesterday by the Nursing (ADoN) initiated. The Do to a lab draw on indicated the bru should have been Assessment shee Review of the fac Condition Moniti 11:42 a.m., which DoN and identifit the following: "Visit is aware of skin I ulcers, or other share is to be asse Documentation of	Assistant Director of and the skin sheet was N felt the bruise was due 7/16/14. The DoN ise to the left hand identified on the Skin t dated 7/21/14. cility policy titled "Skin oring" on 7/24/14 at h was provided by the ed as current, indicated When the Charge Nurse lesions, wounds, venous kin abnormalities, the ssed and documented. of skin conditions must iffication and at least		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155246	B. WING		07/25/2014		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
\\\\	D. INIEL AND T		110 BEVERLY DR				
WATERS	OF DUNELAND T	HE	CHEST	TERTON, IN 46304			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F000314	483.25(c)	CC TO DDEVENT/HEAL					
SS=D	PRESSURE SOR	CS TO PREVENT/HEAL ES					
		prehensive assessment of					
		ility must ensure that a					
		rs the facility without					
	pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were						
	unavoidable; and a	a resident having pressure					
		cessary treatment and					
		te healing, prevent ent new sores from					
	developing.	cht new sores nom					
		ation, record review and	F000314	It is the practice of The Water	00/2 1/201 1		
	interview, the fac	cility failed to ensure		Duneland to constitute credita allegations of compliance with			
	each resident rec	eived the necessary		regulatory requirements. 1. T			
	treatment and ser	rvices to promote healing		actions taken by the facility ar			
	of pressure ulcer	s related to ensuring		follows: a. Head to toe	- D		
		completed as ordered by		assessment was completed o 1. No further issues were	n K		
	the Physician for			identified. 2. The facility's acti	ion		
	•	ssure ulcers of the 3		taken to identify other residen	ts		
	residents who me	et the criteria for		are as follows: a. No further			
	pressure ulcers.	(Resident #12)		residents were affected by the deficient practice. 3. The	,		
	Tr. 1			measures put into place by the	e		
	Findings include	:		facility are as follows: a. Re-inserviced nursing staff on			
	1 On 7/23/14 of	: 10:30 a.m., LPN #1 was		completing through skin			
		ning a pressure ulcer		assessments for any areas of			
	•	sident #12. At that time		discolored skin or areas of	ioon		
		observed in bed laying		discoloration and documentat on the weekly skin assessmen			
		e resident was asked to		4. The facility will monitor act			
		eft side. The pressure		as follows: a. D.O.N. and/or			
		on side. The pressure		designee will monitor complet	ed		

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Facility ID: 000150

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/25/2014
	PROVIDER OR SUPPLIER S OF DUNELAND THE	110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	sore was observed in the sacral area between the resident's buttocks. The area was red with clear bloody drainage observed on the resident's incontinent brief. At that time, there was no gauze sponge observed directly covering the wound. The area was not covered. Interview with LPN #1 at 11:10 a.m. on 7/23/14, indicated there was no gauze sponge observed covering the wound after the resident's brief was pulled down and her buttocks were spread. He further indicated it could have come off during care. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, anxiety, insomnia, pulmonary embolism, spinal bifida, chronic back pain, depression with psychotic features, bipolar, hypothyroidism, hyperglycemia, and hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 7/8/14 indicated the resident's Brief Interview for Mental Status score was a 15, indicating she was alert and oriented. The resident needed extensive assist with one person physical assist for bed mobility. The resident was at risk for		weekly skin assessments and observe by observation 5 time week times 1 month, then 3 tir a week times 3 months and the re-evaluate the need to contine b. The Administrator and/or designee will monitor audits in monthly QA meeting and in the quarterly QA meeting with the Medical Director. The QA team review audits for 6 month Once 100% compliance is reached the QA team will determine when monitoring wistop. 5. Our compliance date 8/24/2014	s a mes en ue. the e

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Event ID:

TCSR11 Facility ID: 000150

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PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155246	B. WIN	G		07/25	/2014
NAME OF F	PROVIDER OR SUPPLIER	-		STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	KO VIDEK OK SOTTEIEN				VERLY DR		
WATERS	OF DUNELAND T	HE		CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pressure ulcers a	nd had one Stage IV					
	pressure ulcer.						
	Review of the cu	irrent plan of care					
	updated 7/2014 i	indicated the resident had					
	_	e sacral area. The					
	_	hes were provide					
	treatment as orde	•					
	Review of the B	raden Scale Assessment					
		ised to determine the risk					
	`	development) dated					
		the resident was a low					
	_	ng pressure ulcers with a					
	score of 18.						
	Review of Physi	cian Orders dated 7/8/14					
	1	e sacral wound with					
		Apply fibersol to wound					
		folded 4 by 4 gauze.					
		sol every Tuesday,					
		aturday. Change 4 by 4					
	1 -	y and as needed (prn) for					
	dislodgement.						
	D. : 64	1					
		ound assessment dated					
		d the resident's pressure					
		um was a Stage IV. The					
	_	easured 4.8 centimeters					
	(cm) by 2.5 cm b	by 1 cm. The tissue					
	remains pink wit	th no odor. The wound					
	edges remained	intact with no tunneling					
	or undermining.	No change in wound					
	_	in facility today and					
	l -		1				ı

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PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155246	A. BUILDING B. WING	00 	COMPLETED 07/25/2014			
	ROVIDER OR SUPPLIER OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	Interview with the Assistant Director of Nursing on 7/24/14 at 12:00 p.m., indicated she measured and kept track of all the wounds in the facility. She further indicated the gauze sponge was to be changed two times a day and as needed if it would have fallen off. She indicated the pressure ulcer should have been covered. 3.1-40(a)(2) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infection. (b) Preventing Spread of Infection (1) When the Infection Control Program						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ISTRUCTION (X3) DATE		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NING	00	COMPL	ETED	
		155246	B. WING	, in vo		07/25/	2014	
NAME OF I	DROLUDED OD GLIDDLIEI		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	C		110 BE	VERLY DR			
WATERS	OF DUNELAND T	HE		CHEST	ERTON, IN 46304			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		resident needs isolation to		TAG	BLI ICILIACI)		DATE	
		d of infection, the facility						
	must isolate the re							
	(2) The facility must prohibit employees with a communicable disease or infected skin							
		t contact with residents or toontact will transmit the						
	disease.	Contact will transmit the						
		st require staff to wash						
	their hands after each direct resident contact							
		ashing is indicated by						
	accepted professi	onal practice.						
	(c) Linens							
		andle, store, process and						
	-	o as to prevent the spread						
	of infection.	ration, record review and	F0004	441	It is the practice of The Waters	s of	08/24/2014	
		cility failed to ensure an	1000	44 1	Duneland to constitute credita		06/24/2014	
	-	•			allegations of compliance with			
		program was maintained			regulatory requirements 1. Th			
		orage of urine collection			facility's actions are as follows a. The plastic urine collection			
		h brushes for 2 of 4 units			container was removed from			
	_	acility (100 and 400			Room 104 b. The tooth brus	h in		
	f *	s ensuring hand washing			Room 401 was cleaned and a			
	1	leted prior to care for 1			plastic bag was placed over the			
		ly observed. (Resident			tooth brush c. The toothbrus Room 405 was removed d. I			
	#50)				50 and R 52 were not affected			
	Findings include	s·			the nurse's aide deficient prac	•		
	1 manigo meidae	••			of failure to wash hands in between resident contact 2. T	he		
	1. On 7/22/14 a	t 9:36 a.m., and on			facility's actions taken to ident			
		o.m., a white plastic			other residents are as follows:			
		i fits over the commode			No other residents were identi by the deficient practice 3. The			
	and is used to collect urine specimens, was observed on the floor behind the				measures put into place by the			
					facility are as follows: a. 100	1%		
		04. The container was			audit of all residents' rooms wa	as		
		a plastic bag. Two			completed. No further issues were identified by the deficien	•		
	1.00 mapped in t	P. P. D. D. D. D. T. 110			were identified by the delicter	ι		

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED
		155246		LDING		07/25/2014
			B. WIN		DDDFGG CITY CTATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
WATER					VERLY DR	
WATERS	OF DUNELAND T	HE.		CHEST	ERTON, IN 46304	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE ACTION OF THE APPROPRIATION OF THE APPROPRIATION OF THE APPROPRIATION OF THE ACTION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	residents resided	in this room.			practice b. Staff was	
					re-inserviced on proper	
	Interview with th	ne Housekeening			placement of toothbrushes and	
		e time, indicated the			urine collection containers c.	
	^				staff was re-inserviced on hand	a
		not have been in the			washing 4. The facility will monitor actions as follows: a.	
	resident's room.				The Department Heads wil ma	
					rounds and monitor for proper	
	2. On 7/22/14 at	9:41 a.m., in Room 401,			placement of tooth brushes an	
	an electric toothl	orush was observed			urine collection containers 5 tir	nes
	laving on the ton	of a 3 compartment			a week. b. the	
		brush was not contained			Administratorand/or designeed	
					will review results of daily roun	ds
	and the brush pa	rt was not covered.			and ensure the concerns are	
					addressed by the appropriate	
	On 7/24/14 at 2::	30 p.m., the electric			Department Head. c. D.O.N.	
	toothbrush was o	observed on the 3			and/or designee will randomly monitor all staff for hand wash	
	compartment sta	nd. The brush part of the			1 time a week times 1 month,	•
	•	ouching the toilet tank.			then monthly times 3 months,	
		sided in this room.			then re-evaluate the need to	
	1 wo residents re	sided in this room.			continue. d. The Administrate	or
					and/or designee will monitor	
	Interview with the				audits in the monthly QA meet	
	Supervisor at the	e time, indicated the top			and in the quarterly QA meetir	
	of the toothbrush	should have been			with the Medical Director. The	
	covered.				QA team will review audits for	
					months. Once 100% complian is reached the QA team will	De
	3 On 7/22/14 at	9:48 a.m., a toothbrush			determine when monitoring will	
		the bathroom shelf in			stop. 5. Our date of compliance	
					is 8/24/2014	
		ontained. Two residents				
	resided in this ro					
	4. On 7/24/14 at	t 7:20 a.m., Restorative				
	CNA #2 was obs	served preparing to				
	provide passive	range of motion (PROM)				
		dent #52. Restorative				
		the resident's room, she				
	was not observed	d to sanitize her hands or	1			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JETIPLE CO	OO	(X3) DATE COMPL	
ANDILAN	or connection	155246	A. BUII		00	07/25/	
		100240	B. WIN		PRESENTE CONTROL OF CORP.	01720	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE VERLY DR		
WATERS	OF DUNELAND T	HE			ERTON, IN 46304		
(X4) ID		FATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	DATE
	to don clean glov	ves before the procedure.					
	_	d providing PROM					
	exercises for the	-					
		d/or ungloved hands.					
		eft the resident's room					
		served to sanitize her					
	hands to retrieve						
		stive device). As she					
	_	ft back to the resident's					
	*	ved Resident #50 seated					
	*	r in the hallway outside					
		s room scratching her					
		ner non-sanitized hands					
		resident's hands from					
		proceeded to wipe her					
		ner eyes. The CNA then					
	-	#52's room with the lift					
		she was observed to wash					
		view at the time with the					
		he should have sanitized					
		completion of the PROM					
	exercises.						
	Review of the ha	and washing policy					
		ovided by the Director of					
	_	on 7/25/14 at 10:00 a.m.,					
	• ,	l-based hand rub should					
		each resident contact.					
	•	f the policy indicated,					
		re personnel's hands are					
		ey should wash with soap					
	and water."	,					
	Interview with th	ne DoN on 7/25/14 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155246	B. WIN			07/25/	2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	eated the CNA should er hands before and after o Resident #52.					
	3.1-18(1)						
F000465 SS=C	TABLE ENVIRON The facility must p sanitary, and come residents, staff and Based on observe facility failed to sanitary environ walls and doors, chairs, and rust s holders on 4 of 4 facility. (100 ha 400 hall) Findings include During the Envir 7/24/14 at 2:20 p Maintenance and Supervisors, the 100 hall a. The inside of Room 104 was p	rovide a safe, functional, fortable environment for d the public. ation and interview, the provide a functional and ment related to marred stained floor tile, marred tained toilet paper units throughout the ll, 200 hall, 300 hall, and ::	F00	0465	It is the practice of the Waters Duneland to constitute credital allegations of compliance with regulatory regulations. 1. The actions taken are as follows: Maintenance has looked at all doors and door frames and ha developed a schedule for repa b. Maintenance has looked at residents room floors and developed a schedule for repa c. All toilet paper rolls have be replaced in all resident rooms Maintenance has observed all resident rooms for holes and a schedule has been developed repairs e. Maintenance has observed all resident room chafor scratched and marred legs and a schedule has been developed for repairs f. Maintenance has observed all resident rooms' toilets for discolored caulks and a sched has been developed for repairs 2. The facility's actions to iden others are as follows a. All rooms were observed and	ole all a. s irs all irs en d. for airs	08/24/2014

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	00	COMPLI	ETED
		155246	A. BUII B. WIN			07/25/2	2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VERLY DR		
WATERS	OF DUNELAND T	HE			ERTON, IN 46304		
WATERS	OF DUNELAND I	ПЕ		CHEST	ERTON, IN 40304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	b. The inside of	the bathroom door in			schedule has been developed		
	Room 109 was p	aint chipped and marred.			3. The measures put into place	9	
	One resident resi	ided in this room.			are as follows: a. A schedule has been developed 4. The		
					facility will monitor as follows:	a	
	200 hall				The Administrator will monitor	a.	
	200 11411				resident's rooms for scheduled	1	
	. Tri. 1 (P	202 11 11			maintenance 3 times weekly		
		loom 202, as well as the			times 3 months b. The		
		nd door frame, were			Administrator and/or designee		
	paint chipped an	d marred. Two residents			monitor audits in the monthly (
	resided in this ro	om.			meetings and in the quarterly (JA	
					meeting with the Medical Director.The QA team will revie	2144	
	b. The base of the	ne door to Room 204 was			audits for 6 months. Once 100		
		d marred. Two residents			compliance is reached the QA		
	resided in this ro				team will determine when		
	restaca ili tilis to	OIII.			monitoring will stop. 5. Our		
	era (4)				compliance date is 8/24/2014		
		located next to the					
	_	oom 209 was discolored.					
	Two of two chair	rs had scratched and					
	marred arms and	legs. The base of the					
	door to the room	was paint chipped and					
		or tile located in front of					
		scolored with gray spots.					
		sided in this room.					
	1 wo residents le	sided iii tiiis 100iii.					
	1 7711 0.4						
		ne door to Room 210 was					
		d marred. The door to					
	the bathroom, as	well as, the bathroom					
	door frame was p	paint chipped and					
	marred. The chai	ir located next to bed A					
	had scratched an	d marred legs. Two					
	residents resided	_					
	1001doing 1001dod	in mis room.					
	200 hall						
	300 hall						
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155246	B. WIN			07/25/2014
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	C .		110 BE	VERLY DR	
	OF DUNELAND T			<u> </u>	ERTON, IN 46304	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
		nole in the wall behind				
		n 307. Two residents				
	resided in this room.					
	b. The door to to	he bathroom in Room				
	312 was paint chipped and marred. Two					
	residents resided	l in this room.				
	400 hall					
	a. The inside of	the bathroom door and				
	the bathroom do	or frame were paint				
		rred. Two residents				
	resided in this ro					
	Testaca in time re	, (11)				
	h The bathroon	n door and door frame as				
		to Room 402, were paint				
		•				
		rred. Two residents				
	resided in this ro	oom.				
	The install	'41. a 1. a 41				
		the bathroom door and				
		vere paint chipped and				
		405. Two residents				
	resided in this ro	oom.				
	d. The bathroon	n door and door frame				
	were paint chipp	ed and marred in Room				
	411. Two reside	nts resided in this room.				
	e. The bathroon	n door and door frame in				
	Room 413 were	paint chipped and				
	marred. The wall next to the closet was					
		red. The toilet paper				
		ed and loose. Two				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		A. BUILDING 00			COMPLETED 07/25/2014		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VERLY DR		
	OF DUNELAND T	HE .			ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	paint chipped and the bathroom and paint chipped and paper holder had caulking around discolored. Two room. Interview with the Supervisor at the	e wall in Room 414 was d marred. The door to d the door frame were d marred. The toilet areas of rust. The the base of the toilet was residents resided in this					
F000498 SS=D	able to demonstrate and techniques ne residents' needs, a resident assessme plan of care. Based on observatinterview, the factor CNAs did not prayed the related to removing pressure ulcers for the same and the sa		F000	0498	It is the practice of The Waters Duneland to constitute creditat allegations of compliance with regulatory regulation 1. The actions taken by the facility are follows: a. C.N.A. removed wound dressing of R 12 2. The facility's actions to identify other	ole all e as	08/24/2014

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIG	00	COMPL	ETED
		155246	A. BUII B. WIN	LDING		07/25/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			VERLY DR		
WATER!	S OF DUNELAND T	HE.			ERTON, IN 46304		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
TAG		<u> </u>	+	TAG	are as follows: a. No further		DATE
		et the criteria for			residents were identified r/t		
	pressure ulcers.	(Resident #12)			deficient practice 3. The		
					measures put into place are a		
	Findings include				follows: a. All C.N.A.'s were re-educated and re-inserviced		
	1 0 5/00/14	. 10.00			not removing wound dressing		
	1. On 7/23/14 at 10:30 a.m., LPN #1 was				The facility will monitor action		
	_	ming a pressure ulcer			follows; a. D.O.N. and/or		
		esident #12. At that time			designee will randomly monitor	or	
		observed in bed laying			certified nursing assistants		
	on her back. Th	e resident was asked to			perform resident care to assu C.N.A.'s are practicing within		
	roll onto to her left side. The pressure sore was observed in the sacral area				realm 5 times a week times 1	uicii	
					month, then 3 times a week ti	mes	
	between the resi	dent's buttocks. The area			3 months and then will detern	nine	
	was red with cle	ar bloody drainage			the need to continue. b. The		
		resident's incontinent			administrator/or designee will		
		ne, there was no gauze			monitor audits in the monthly meeting and in the quarterly (
		d directly covering the			meeting with the Medical Dire		
		a was not covered.			The QA team will review audi		
	would. The are	a was not covered.			for 6 months. Once 100%		
	Instanciano verith I	DN #1 of 11:10 o m on			compliance is reached the QA	4	
		LPN #1 at 11:10 a.m. on			team will determine when	ato	
		ed there was no gauze			monitoring will stop. 5. Our d of compliance is 8/24/2014	ait	
		d covering the wound			51 50111pilatioc is 0/24/2014		
		t's brief was pulled down					
		s were spread. He further					
		d have come off during					
	care. He indicat	ted he was not made					
	aware the dressi	ng had fallen off or was					
	removed.						
	Interview with	CNA #1 on 7/23/24 at					
	11:12 a.m., indi	cated she had taken care					
	· ·	oday. She indicated she					
		repositioned the resident					
		the resident's brief after					
	and nad changed	i die resident's offer after			1		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246		LDING	NSTRUCTION 00	(X3) DATE COMPI 07/25	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE	
	CNA indicated s gauze sponge that pressure sore bed drainage on it. S had not informed	was about 9:30 a.m. The he had removed the at was directly on the cause it had a lot of the then indicated she had gotten side tracked it.						
	resident's diagno not limited to, re insomnia, pulmo bifida, chronic be psychotic feature	3/14 at 10:18 a.m. The ses included, but were spiratory failure, anxiety, nary embolism, spinal ack pain, depression with						
	indicated cleanse normal saline. A bed, cover with the Apply new fibers Thursday, and Sa	cian Orders dated 7/8/14 e sacral wound with apply fibersol to wound folded 4 by 4 gauze. sol every Tuesday, aturday. Change 4 by 4 y and as needed (prn)						
	Nursing on 7/24/ indicated she me all the wounds in indicated the gau	ne Assistant Director of (14 at 12:00 p.m., asured and kept track of a the facility. She further tize sponge was to be es a day and as needed if						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	(X2) MU A. BUILI B. WING	DING	ONSTRUCTION 00	(X3) DATE COMPL 07/25 /	LETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE			STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	the CNA should	llen off. She indicated not have removed the om the pressure ulcer.						

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